

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2013
NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00136117, IN00137107, IN00137922, and IN00138560.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00137120 and IN00137473 completed on October 8, 2013.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00134339 and IN00134814 completed on August 23, 2013.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00128277 and IN00129429 completed on July 26, 2013.</p> <p>Complaint IN00136117- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00137107- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00137922- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00138560-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 23, 24, 25, 28, & 29, 2013</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>Survey team: Janet Adams, RN, TC Heather Hite, RN October 28, 2013</p> <p>Census bed type: SNF: 6 SNF/NF: 116 Total: 122</p> <p>Census payor type: Medicare: 17 Medicaid: 100 Other: 5 Total: 122</p> <p>Sample: 25</p> <p>Timberview Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00136117, IN00137107, IN00137922, and IN00138560.</p> <p>Quality review completed on October 31, 2013, by Janelyn Kulik, RN.</p>	F 000			